STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING _____ B. WING _____	C 04/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	**31869 CHICAGO TR NEW CARLISLE, IN 46552**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for an Investigation of Complaint #IN00147335.

Complaint IN00147335 - Substantiated. No deficiencies related to the allegations are cited.

Survey date:
April 28 and 29, 2014

Facility number: 000427
Provider number: 155672
AIM number: 100275150

Survey team:
Shelly Miller- Vice, RN

Census bed type:
SNF/NF: 76
Total: 76

Census payor type:
Medicare: 8
Medicaid: 49
Other: 19
Total: 76

Sample: 3

Hamilton Grove was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2. in regard to the Investigation of Complaint IN00147335.

Quality Review 04/30/14 by Lisa McColly

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE